STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065166	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Poudre Canyon Rehabilitation and Nursing, LLC	1000 S Lemay Ave Fort Collins, CO 80524

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51915 Based on interviews and record review, the facility failed to protect and promote an environment free from resident-to-resident sexual and physical abuse. The facility failure affected five of five residents reviewed for abuse (#1, #18, #168, #25 and #169) out of 38 sample residents. The facility's failure contributed to incidents of abuse by Residents #50 and #43 and created the potential the abuse would recur. Resident #50 had a history of sexually inappropriate behaviors. On 1/1/25, he was observed rubbing Resident #1's back and putting his hand down the front of her shirt. Resident #1 reported to the facility that he had done the same to other residents. Resident #50 was placed on 15-minute checks; however, interviews with staff on 1/14/25 revealed not all staff were aware of the resident's inappropriate behavior, aware he was to be monitored every 15 minutes, or educated on how to respond to his behavior toward female residents. The facility's failure to monitor Resident #50's sexually inappropriate behavior before and after the incidents on 1/1/25 put other residents at risk for sexual abuse. Resident #43 had a history of physical altercations and hit Resident #168, pushed Resident #169, and grabbed and shoved Resident #25. The facility failed to take steps to keep Residents #168, #169, and #25 free from abuse and the potential for harm. Findings include: I. Immediate jeopardy A. Findings of immediate jeopardy Resident #50, who was admitted to the facility in September 2023, had a history of sexually inappropriate behaviors. The facility failed to prevent Resident #50 from massaging Resident #1's back and breast on 1/1/25. Resident #1 indicated during the facility investigation of the incident that Resident #50's touching made her uncomfortable. Further, Resident #1 reported Resident #50 had done the same things to other residents, identifying Resident #18 who, per her care plan, was at risk of being a victim. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The facility's response to the incident on 1/1/25 was to implement every 15-minute safety checks for Resident #50. However, the safety checks were not consistently implemented based on staff interviews which further identified staff was not aware of Resident #50's behavior or the intervention of the safety checks. The facility's failure to monitor Resident #50's sexually inappropriate behavior before and after the incidents on 1/1/25 put other residents at risk for sexual abuse. The lack of awareness and sufficient monitoring created a likelihood of serious harm to residents at risk. On 1/15/25 at 6:00 p.m., the nursing home administrator (NHA) was notified the facility's failure created an immediate jeopardy situation. B. Facility plan to remove immediate jeopardy On 1/16/25 at 2:25 p.m., the facility submitted a plan to remove the immediate jeopardy. The plan read: Immediate Action: Nursing Home Administrator (NHA) has assigned a one-to-one staff member to ensure that Resident #50 is prevented from perpetuating further sexual abuse of resident 1, 18 and other residents. This will ensure that Resident #1, #18 and other residents are protected from Resident #50. The 1:1 staff assignment will continue until the interdisciplinary team is able to coordinate with Behavioral Health Solutions provider, speech therapist and medical director to determine a less restrictive plan of care that will safely and effectively mitigate the risk for sexual behaviors directed towards others. Completed: 1/15/25 Beginning 1/15/25, NHA or designee will inservice the one-to-one staff member regarding the responsibilities of the 1:1 staff member before the start of the shift to ensure the 1:1 staff member understands their responsibilities. Beginning 1/14/25, Director of Nursing (DON) or designee will complete education with all staff before their first shift back to work to ensure they receive updated training and education on Resident #50's care needs and behavioral interventions as documented in the care plan and Kardex. Completion date: 1/16/25 Beginning 1/15/25, DON or designee will complete a comprehensive medical record review and interviews with direct care staff to identify any residents with sexually inappropriate behaviors and update the comprehensive care plan and Kardex with effective interventions based on the identified risk factors to keep other residents safe from sexual abuse. Completion date: 1/16/25 Identification of Other Residents Potentially Affected by the Deficient Practice: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	DON or designee will complete interviews with all residents or resident representatives to identify any residents who have experienced unwanted touching and initiate abuse reporting and update the comprehensive care plan with effective interventions based on the identified risk factors to keep other residents safe from sexual abuse. Completion date: 1/15/25 Measures to Ensure the Deficient Practice Does Not Recur: Beginning 1/15/25, DON or designee will complete education with all staff before their first shift back to work to ensure they receive updated training and education on resident-specific behavior interventions, reporting expectations including reporting any observed physical touching between residents to the abuse coordinator, accessing care plans and Kardexes and expectations for review of care plans and Kardexes at the start of each shift for any changes. C. Removal of immediate jeopardy On 1/16/25 at 2:25 p.m., the nursing home administrator (NHA) was notified that the facility's plan to remove the immediate jeopardy was accepted based on the facility's plan and evidence of implementation of the measures outlined in the plan. However, the deficient practice remained at an E level, the potential for more than minimal harm at a pattern. II. Failure to prevent sexual abuse - incidents involving Residents #50, #1, and #18 A. Facility abuse policy The facility's abuse policy, revised on 6/11/24 was received from the NHA on 1/22/25 at 4:15 p.m. It read in pertinent part: Every resident has the right to be free from all forms of abuse: verbal, sexual, physical, mental, neglect, corporal punishment and involuntary seclusion. This facility does not condone resident abuse and shall take every precaution to prevent resident abuse. All occurrences of resident abuse, suspected abuse, neglect and injuries of unknown source shall be promptly reported to the facility abuse coordinator for investigation. Pre-assessment of potential residents is done during the admission process to screen for potential signs of abusive behavior. Residents whose medical, physical, mental, behavioral or psychosocial needs cannot be met based on the facility's staffing patterns, staff qualifications, competency and knowledge, clinical resources, physical environment and equipment shall not be admitted . Residents identified in the pre-admission assessment period to be at risk to have aggressive or abusive behaviors shall have comprehensive care plans written to include approaches to reduce or eliminate the risk for abuse. The facility will ensure that all residents are protected from physical and psychosocial harm during and after abuse investigations, including but not limited to: -Responding immediately to protect the alleged victim; (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	-Examining the alleged victim for any sign of injury, including a physical examination and/or psychosocial assessment as indicated; -Increased supervision of the alleged victim and other residents as indicated; -Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; -Protection from retaliation; and -Providing emotional support and/or counseling to the resident during and after the investigation as needed Residents with aggressive or abusive behaviors shall have their care plans written and revised as needed to include approaches to reduce or eliminate the risk for abuse. B. Incident 1/1/25 - Sexual abuse of Resident #1 by Resident #50 A progress note in Resident #50's record on 1/1/25 documented in part: This resident was observed by (a) speech therapist to be rubbing (Resident #1's) back and went down the top front of her shirt. I talked with (Resident #1) to see if she had given consent and she had; she said she was also ok with him going in the front of her shirt; they were at the puzzle table by therapy. C. Resident #50 1. Resident status Resident #50, age 68, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), the resident's diagnoses included Parkinson's disease without dyskinesia, with fluctuations, cognitive communication deficit, chronic lymphocytic leukemia of B-cell type, anxiety disorder, gastro-esophageal reflux disease without esophagitis, and unspecified dementia, unspecified severity, with other behavioral disturbance. The 1/15/25 minimum data set (MDS) assessment, revealed the resident was cognitively intact, with a brief interview for mental status (BIMS) score of 15 out of 15. He required assistance from one person with activities of daily living (ADLs). The care plan for the use of psychotropic medications, dated 11/3/23, revealed the resident was taking medications for depression and anxiety. 2. Record review revealed documentation of the resident's history of inappropriate sexual behavior. An 8/1/23 neurology note revealed Resident #50 had a history of impulsive behaviors for which pharmacological measures and non-pharmaceutical and lifestyle measures were prescribed to decrease sexual behaviors, and it indicated the resident required 24-hour supervision. An activities care plan, initiated on 9/15/23 and revised on 12/11/24, revealed the resident's daughter asked staff not to take the resident on public outings due to sexually inappropriate behaviors and self-exposure. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	However, contrary to facility policy (see above), record review revealed there was no care plan directing staff to monitor the resident for sexually inappropriate behaviors in the facility. 3. Resident interview Resident #50 was interviewed on 1/15/25 at 2:55 p.m. He said he remembered the incident on 1/1/25 and confirmed he touched Resident #1's breast without her consent. He said, It feels like an impulse that I cannot control and I feel bad after I do it. D. Resident #1 Resident #1, age 65, was admitted on [DATE]. According to the January 2025 CPO, the resident's diagnoses included generalized idiopathic epilepsy and epileptic syndromes, cognitive communication deficit, history of traumatic brain injury, sleep apnea, depression, and gastro-esophageal reflux disease without esophagitis. The 12/10/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required assistance from one person with activities of daily living (ADLs). No behaviors were noted. 1. Record review The current care plan revealed the resident had post-traumatic stress disorder (PTSD), and poor safety awareness. She required reminders regarding safety concerns. 2. Interviews Resident #1 was interviewed on 1/13/25 at 9:30 a.m. Resident #1 did not mention or recall the incident on 1/1/25. However, the resident's interview documented on the facility incident report (see below) read Resident #50 made her uncomfortable by touching her, and licensed practical nurse (LPN) #1, interviewed on 1/14/25 at 4:15 p.m., stated Resident #1 complained about Resident #50 massaging her because he touched her breast. The record did not reveal evidence the resident's ability to consent to sexual behaviors had been assessed. Documentation in the facility incident report (see below) revealed Resident #1 also reported Resident #50 had exhibited the same behavior toward Resident #18. E. Resident #18 Resident #18, age less than 65, was admitted on [DATE]. According to the January 2025 CPO, the resident's diagnoses included unspecified schizoaffective disorder, unspecified protein caloric malnutrition, delusional disorder, major depressive disorder, mild cognitive impairment of unknown etiology, personal history of mental and behavioral disorders, psoriasis, paroxysmal atrial fibrillation, muscle wasting and atrophy, type 2 diabetes mellitus, and cirrhosis. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The 11/12/24 MDS assessment revealed Resident #18 was cognitively intact with a BIMS score of 15 out of 15. However, she had the potential for impaired cognitive function with a diagnosis of minor cognitive impairment. She was alert and able to make her needs known; however, she required time to process and respond to others. She had an ADL self-care performance deficit and required assistance with ADLs and mobility. Her physical abilities fluctuated, requiring extensive assistance. Resident #18, in an interview on 1/13/25 at 11:15 a.m., said she was treated with respect and dignity and did not observe/experience any situations of abuse in the facility. However, the resident's care plan, initiated on 3/2/21, stated Resident #18 was at risk of being the victim or involved in a resident-to-resident altercation related to behavior or instigating altercations. It also stated she should not be involved in any altercations, should be monitored during activities, and should not be close to residents with whom she could have a negative interaction. An interview with LPN #1 on 1/14/25 at 4:15 revealed the LPN had observed Resident #50 touching Resident #18's back on at least one occasion. She said she asked Resident #18 about it when it occurred and Resident #18 said she did not mind the touch. A review of the resident's care plan did not mention that Resident #18 was involved in a consensual relationship with Resident #50 or that she was okay with him touching her. Further, record review revealed no evidence that the resident's ability to consent had been assessed. E. Facility Response to the incident on 1/1/25 involving Resident #50 and Resident #1 1. Facility incident report The 1/1/25 facility incident report revealed a staff member witnessed Resident #50 removing his hands from Resident #1's chest. The report read: -The facility staff separated the residents, called the police, and followed the procedures regarding sexual abuse, including reporting it to other authorities. -Immediate interventions included to request an assessment by a behavioral health therapist (for Resident #50), to monitor Resident #50 in common areas, and to redirect the resident when he attempted to give massages. -An interview with the victim, Resident #1, revealed that Resident #50 made her uncomfortable by touching her and she reported that he had done it to other residents, naming Resident #18. 2. Neurological evaluation of Resident #50 Documentation of an evaluation of Resident #50 by a neurologist on 1/2/25 read: (Resident #50) was recently placed on alert charting due to a resident-to-resident altercation involving sexual advances towards another resident who did consent. (But see above; conflicting information on Resident #1's consent to Resident #50's behavior.) Continued monitoring is in place to address this behavioral issue. Plan: Continue alert charting and monitoring for inappropriate sexual behavior. F. Failures in facility response (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	1. Failure to chart and monitor Resident #50 for inappropriate sexual behavior as planned (see above). A review of progress notes, medication administration orders (MARs), and treatment administration orders (TARs) revealed that starting 10/9/24, the resident was monitored for signs and symptoms of psychosis, delusions, mood changes, and physical aggression. However, there was no mention of monitoring for inappropriate sexual behaviors, monitoring the resident in common areas, redirecting and tracking sexually inappropriate behaviors as recommended after the 1/1/25 incident. A review of progress notes revealed monitoring the resident every 15 minutes was documented only once in the progress notes on 1/2/25. -A review of the logs for 15-minute checks revealed the resident was monitored on 1/1/25, and 1/3/25 - 1/10/25. 2. Failure to assess Resident #1 and Resident #18's ability to consent to sexual behaviors. See above; there was no evidence that the two residents identified as being touched by Resident #50 were assessed for their ability to consent. 3. Failure to investigate whether other residents, including those cognitively impaired on the unit, had been touched inappropriately by Resident #50. The facility incident report and interviews with staff (see below) revealed no evidence that the facility investigation included an evaluation of the relationship of other residents on the unit with Resident #50 after Resident #1 reported he had done it to others. F. Staff interviews Staff interviews revealed not all staff were aware of Resident #50's inappropriate sexual behavior, not aware of the expectation his behaviors would be monitored every 15 minutes and charted, and not educated on what the appropriate response to observed sexual behavior by Resident #50 should be. 1. LPN #1 was interviewed on 1/14/25 at 4:15 p.m. She said Resident #50 was an alert and oriented resident. He did have sexually inappropriate behaviors and was on 15-minute checks to ensure he was not close to other female residents. 2. Certified nurse aide (CNA) #4 was interviewed on 1/14/25 at 4:30 p.m. She said Resident #50 was alert and oriented and able to move independently in his wheelchair throughout the building. She said she heard from other staff members that the resident occasionally had sexually inappropriate behaviors toward staff but never toward residents. She said she was not aware of any special monitoring for Resident #50. (continued on next page)

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	065166	A. Building B. Wing	01/22/2025

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	3. CNA #5 was interviewed on 1/14/25 at 4:45 p.m. She said Resident #50 was an alert and oriented resident, he was pleasant, and likes to give massages to ladies. She said she observed Resident #50 giving a massage on the back to Resident #18 on a couple of occasions. She said she did not separate the residents when she observed it because Resident #18 seemed not to mind it. 4. CNA #6 was interviewed on 1/14/25 at 5:00 p.m. She said she did not know Resident #50 well and was not aware of any behaviors that she should be observing him for. 5. CNA # 7 was interviewed on 1/14/25 at 5:20 p.m. She said Resident #50 was independent in an electric wheelchair and could move around the building. She said he did not have any inappropriate behaviors, but said there was an incident two weeks ago. She said Resident #50 occasionally rubbed Resident #18's back but she did not think it was inappropriate because it was on the back. She said Resident #18 was independent as well and she could have moved away from Resident #50 at any time. 6. The director of nursing (DON), NHA, and the regional director of quality and compliance (RDQC) were interviewed on 1/14/25 at 5:30 p.m. The DON mentioned she was unaware of Resident #50's sexual behavior history. They stated that after the incident (on 1/1/25), we separated them, established every 15-minute checks on Resident #50, and he has been redirected and told that he should not be touching others. The NHA stated Resident #50 had a history of sexually inappropriate behaviors; however, he had not displayed any behaviors until the incident on 1/1/25. After the incident, the resident was placed on 15-minute checks to ensure staff were aware of his location and whereabouts. The NHA said all staff were educated on the plan of care for Resident #50. The NHA stated she was not aware that staff were not following 15-minute checks for Resident #50. She said she would start immediate education for all staff on duty. She said Resident #18 was not formally assessed for consent, but was asked about the situation and she did not mind the backrubs as long as they did not go any further. 7. The NHA was interviewed in the presence of the DON and the RDQC on 1/15/25 at 12:30 p.m. She said all staff in the building were educated before starting their shift on what could be considered inappropriate sexual behavior. She said Resident #50 had been placed on a 1:1 monitoring to ensure he was not in close contact with female residents. In addition, all other residents were reviewed to ensure they did not have a history of inappropriate behaviors that should be monitored. 50315 III. The facility failed to ensure Residents #168, #169, and #25 were free from physical abuse from Resident #43. Resident #43 had a history of physical altercations. He hit Resident #168, pushed Resident #169, and grabbed and shoved Resident #25. A. Facility policy and procedure The Abuse policy and procedure, revised on 6/11/24, was provided by the regional director of quality and compliance (RDQC) on 1/22/25 at 4:55 p.m. It documented in pertinent part, Every resident has the right to be free from all forms of abuse: verbal, sexual, physical, mental, neglect, corporal punishment and involuntary seclusion. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	B. Incident on 5/13/24 between Resident #43 and Resident #168 1. Facility investigation A 5/13/24 abuse investigation documented there was a witnessed physical altercation between two residents. The residents were separated, assessed, and placed on one-to-one monitoring. Resident #168 said her fingers hurt and an x-ray was ordered. Resident #43 was interviewed on 5/13/24 and when asked if he grabbed another resident, he shook his head no. When Resident #43 was asked if he hit another resident, he shook his head Yes. When Resident #43 was asked if another resident grabbed him, he shook his head no. Resident #168 was interviewed on 5/13/24 and did not remember the incident. She complained of her fingers hurting. Four residents were interviewed with no additional information. Five staff members were interviewed. CNA #1 was interviewed on 5/13/24 and said she heard yelling from the hallway. She exited a room to find Resident #43 holding the hand of Resident #168. CNA #1 reported Resident #168 appeared to be pulling her hand away from Resident #43 and Resident #43 was agitated and unable to communicate with staff what occurred. Both parties were separated and easily directed. LPN #1 said resident #43 had been on edge lately and had recently had a gradual dose reduction. The incident was not substantiated. 2. Resident #43 a. Resident #43's status Resident #43, age 63, was admitted on [DATE]. According to the January 2025 CPO, the resident's diagnoses included cerebral infarction (stroke), aphasia (difficulty with expression), and cognitive communication deficit. The MDS assessment revealed the resident was rarely/never understood and a brief interview for mental status (BIMS) was not completed. The staff assessment for mental status revealed his memory was okay. He required set-up assistance with eating and was independent for hygiene, bathing, transfers, and dressing. It indicated the resident did not have verbal behavioral symptoms directed toward others such as threatening others, screaming at others, or cursing at others. b. Record review (continued on next page)

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	065166	A. Building B. Wing	01/22/2025

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The behavior care plan, revised on 2/23/23, revealed the resident was at risk for resident-to-resident altercations and that he had a history of physical altercation with another resident. The interventions included to: analyze times of the day, places, circumstances, triggers, and what deescalates the behavior and document as needed, assess for roommate compatibility, encourage the resident to not assist with clearing the dining room tables until after residents have left, increase supervision while the resident was in communal areas where he may be likely to attempt to care for others and when the resident became agitated, to intervene before the agitation escalated (guide away from the source of distress, engage calmly in conversations). The nursing progress note, dated 5/13/24 at 12:13 p.m., documented that the resident was on continued charting for an altercation with another resident. There were no other altercations that shift. 3. Resident #168 a. Resident #168's status Resident #168, age 73, was admitted on [DATE] and discharged on [DATE]. According to the CPO, the diagnoses included dementia, dependence on wheelchair, and bipolar disorder. The 4/8/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of zero out of 15. She required set-up assistance for eating and oral hygiene. She required partial/moderate assistance with bathing and supervision for transfers. b. Record review The behavior care plan, revised 2/2/23, documented Resident #168 had a behavior problem and that she made false allegations about other residents and staff about hitting and kicking her. She took other resident's belongings and refused cares, like bathing and changing clothes. Interventions included: taking medications as ordered, anticipating her needs, caregivers to provide opportunity for positive interaction, intervening as necessary to protect the rights and safety of other residents, monitoring behavior episodes, redirecting with music/foods/fluids, and changing her environment. The nursing progress note dated 5/13/24 documented that it was reported to the nurse that Resident #168 had her hair pulled and her fingers pulled by another resident. The primary care provider (PCP), DON, and power of attorney (POA) were notified. An x-ray was ordered and results were pending. Scheduled pain medication was administered as ordered. C. Incident on 5/18/24 between Resident #43 and Resident #169 1. Facility investigation A 5/18/24 abuse investigation documented there was a witnessed physical altercation between two residents. The residents were separated, assessed, and placed on one-to-one monitoring. Resident #43 was interviewed on 5/18/24 and when asked if he grabbed another resident, he shook his head no. When Resident #43 was asked if he pushed anyone, he shook his head yes and pointed to his feet. When Resident #43 was asked if the victim hit his foot, he shook his head Yes. When asked if he was afraid of anyone, Resident #43 shook his head No. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065166	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Poudre Canyon Rehabilitation and Nursing, LLC	1000 S Lemay Ave Fort Collins, CO 80524

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Resident #169 was interviewed on 5/13/24 and said she was trying to go to her spot in the dining room when her foot slipped and accidentally kicked Resident #43. Resident #43 then grabbed her by her shirt collar and pushed her away from him. She denied being hurt or afraid of Resident #43. Four residents were interviewed with no additional information. Five staff members were interviewed. CNA #2 was interviewed and reported she witnessed the incident. She reported seeing both residents cross paths in the dining room and she saw Resident #169 kicking her foot out to propel herself backward. CNA #2 could not tell but thought the resident's foot slipped while propelling and thought Resident #43 may have thought she was kicking at him. She reported Resident #43 then grabbed the shirt collar of Resident #169 and pushed her away from him. CNA #2 reported the two residents seemed to go about their business and not interact further. The incident was not substantiated. 2. Resident #43 a. See the resident's status and behavioral care plan above b. Record review A nursing progress behavior note, dated 5/17/24, documented Resident #43 did not want to take his medications. Another nursing progress note, dated 5/18/24, documented that staff came to the nurse to say Resident #43 was accidentally run into by another resident and Resident #43 got upset. Resident #43 grabbed the victim by the front of her shirt on the chest and shoved/pushed her backward in the wheelchair. The victim went wheeling backward. Both residents were separated and placed on one-to-ones for the rest of the shift. 3. Resident #169 a. Resident #169's status Resident #169, age less than 65, was admitted on [DATE] and discharged on [DATE]. According to the CPO, the diagnoses included end-stage renal disease, depression, anxiety, and type II diabetes. The 6/9/24 MDS assessment revealed the resident had mild cognitive impairment with a BIMS score of 13 out of 15. She required substantial assistance for bathing and partial assistance for dressing and hygiene. She required supervision for transfers. b. Record review The nursing progress note, dated 5/18/24, documented a change in condition for Resident #169. It was documented that Resident #169 was forcefully grabbed by her clothing by another resident. There were no injuries acquired. There was nothing documented in Resident #169's care plan regarding behaviors or the resident-to-resident altercation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065166	A. Building B. Wing	01/22/2025

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	D. Incident on 7/3/25 between Resident #43 and Resident #25 1. Facility investigation A 7/3/24 abuse investigation documented there was a witnessed physical altercation between two residents. The residents were separated, assessed, and placed on one-to-one monitoring. Resident #25 sustained a skin tear to his right hand. Resident #43 was interviewed on 7/3/24 and was unable to verbally articulate. When asked if he was attacked, he shook his head No. When Resident #43 was asked if he attacked anyone, he shook his head No. When asked if he was afraid of anyone, Resident #43 shook his head No. Resident #25 was interviewed on 7/3/24 and reported he did not know why Resident #43 grabbed him. He reported he was just sitting there waiting for his food. He reported he could not really remember what happened; he knew he was grabbed and that he had a scratch on his hand. He had to pull his shirt away from Resident #43 to get away. Resident #25 reported he was not fearful but that he did not want to be around Resident #43. Four residents were interviewed with no additional information. Five staff members were interviewed. The resident aide (RA) was interviewed on 7/3/24 and reported she was passing drinks in the dining room when she saw Resident #43 coming into the dining room and grabbing the shirt of Resident #25. She reported Resident #25 was trying to pull away and she went to get the nurse. They assisted in separating the two residents. The incident was substantiated. 2. Resident #43 a. See Resident #43's status and care plan above b. Record review The nursing progress note, dated 7/2/24, documented that the nurse heard Stop it, let him go! The nurse grabbed her medications and went into the dining area. Resident #43 had Resident #25 pulled up from his chair toward him in the wheelchair. Resident #43 had Resident #25's shirt clenched in his hand. The nurse informed Resident #43 to let go of the shirt as the nurse assisted the resident's hand away from the shirt. A nursing student also assisted with separating the two residents. The nursing student was instructed to assist Resident #43 back to his room. The RA was instructed to make sure Resident #25 had eaten breakfast and had something to drink. The abuse coordinator was notified. 3. Resident #25 a. Resident #25's status Resident #25, age 81, was admitted on [DATE]. According to the January 2025 CPO, the resident's diagnoses included chronic heart failure, anxiety, and alcohol dependence. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065166	A. Building B. Wing	01/22/2025

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The 1/3/25 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 8 out of 15. He required partial/moderate assistance for bathing and set-up assistance for hygiene, dressing, toileting, and transfer. b. Record review The trauma-informed care plan, revised 8/13/24, documented Resident #25 was at increased risk for the development of mood or behavioral symptoms. Interventions included: assessing the resident's need for additional services and therapeutic support and exploring/offering peer support services with relevant cultural similarities as requested by the resident. The nursing progress note, dated 7/3/24, documented that Resident #25 had an altercation with another resident. The

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	065166	A. Building B. Wing	01/22/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315 Based on observations, record review and interviews, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice for two (#167 and #64) of five residents reviewed for quality of care out of 38 sample residents. Specifically, the facility failed to: -Ensure Resident #167's physician was notified in a timely manner when attempts to start an intravenous (IV) line were unsuccessful and staff could not administer IV fluids per the physician orders; and, -Ensure Resident #64's laboratory (lab) blood work was addressed by the resident's physician in a timely manner. Findings include: I. Facility policy The Change in a Resident's Condition or Status policy and procedure, revised 12/19/16, was received from the regional director of quality and compliance (RDQC) on 1/22/25 at 4:55 p.m. It documented in pertinent part, The nurse supervisor or charge nurse will notify the resident's attending physician or on-call physician when there has been a change in condition, including a significant change in the resident's physical/emotional/mental condition or a need to alter the resident's medical treatment significantly. II. Resident #167 A. Resident status Resident #167, age 70, was admitted on [DATE] and discharged to the hospital on 11/11/24. According to the January 2025 computerized physician orders (CPO), diagnoses included carotid artery aneurysm (bulge in the artery that supplies brain/head with blood flow), dysphagia (difficulty with swallowing) and depression. The 10/17/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. She required extensive/maximal assistance with toileting, bathing, hygiene, sit to stand transfers and chair to bed transfers. B. Record review A nursing progress note, dated 11/1/24 at 2:45 p.m., documented Resident #167 had sustained a change in condition related to falls, shortness of breath and decreased urine output. Vital signs documented at the time included an oxygen saturation of 83% (percent) on room air. (continued on next page)

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	065166	A. Building B. Wing	01/22/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note dated 11/1/24 at 3:56 p.m., documented that Resident #167's primary care provider (PCP) gave a physician's order for a stat (immediate) D-dimer (blood test to rule out a blood clot), chest x-ray, two liters per minute of oxygen via nasal cannula, to start a peripheral IV and to administer one liter of 0.9% normal saline solution. It was documented to notify the PCP after completion of the orders and to follow up with any presentation of becoming hemodynamically unstable (unstable movement in blood resulting in inadequate blood flow). A nursing note, dated 11/1/24 at 5:45 p.m., documented that the nurse attempted to start an IV twice on Resident #167 and was unsuccessful. -Review of Resident #167's electronic medical record (EMR) failed to reveal documentation that the resident's PCP was notified when the nurse was unable to start the IV in order to administer the physician ordered normal saline solution (see above). A nursing note, dated 11/2/24 at 6:48 a.m., documented a nurse attempted to start an IV and the resident tolerated it well. However, the IV attempt was unsuccessful and the provider was notified. -However, there was no documentation in Resident #167's EMR to indicate what was recommended by the physician when the IV attempts were unsuccessful. C. Staff interviews The RDQC, the director of nursing (DON) and the nursing home administrator (NHA) were interviewed together on 1/16/25 at 2:35 p.m. The DON said when a resident experienced a change in condition, the nurse on duty was to notify the physician, the DON and the resident's family or medical power of attorney (POA). She said orders from the physician were to be completed right away unless there was another emergency going on. She said if a nurse was unable to get an IV initiated, the process was to have another nurse attempt, notify the DON and call the RDQC to get someone to come in to place the IV. The RDQC said the facility could also call for emergency medical services (EMS) to put an IV in. Nurse practitioner (NP) #1 was interviewed on 1/16/25 at 1:19 p.m. NP #1 said she would expect to be notified right away if a nurse was unable to carry out a treatment order for a resident. She said this would potentially change the treatment plan for the resident. Registered nurse (RN) #2 was interviewed on 1/21/25 at 10:45 a.m. RN #2 said if a resident was experiencing a change in condition, she would assess the resident, call the provider and call the nursing supervisor. She said if she could not follow a provider's order, she would notify the provider right away. Primary care physician (PCP) #1 was interviewed on 1/22/25 at 11:26 a.m. PCP #1 said she was notified of Resident #167's change in condition on 11/1/24 and ordered a peripheral IV with fluids. She said she was not notified by the nursing staff until 11/2/24 that the nursing staff was unable to place the IV. She said if she had been notified earlier, she may have sent Resident #167 to the emergency room if the resident was agreeable. 37166 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Resident #64 A. Resident status Resident #64, age greater than 65, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included type 2 diabetes, history of stroke and hypertension. The 7/28/24 MDS assessment revealed the resident was moderately cognitively intact with a BIMS score of 10 out of 15. The resident required moderate assistance with activities of daily living (ADL). B. Record review The primary care provider note dated 11/8/24 documented that Resident #64 was assessed by the physician as he had been off. The resident was skipping meals and smoke breaks. The physician placed physician's orders to obtain blood work for the resident. The blood work was completed by the lab on 11/8/24 and was submitted to the physician's office and facility for review via the EMR. -There was no documentation in Resident #64's EMR to indicate that the resident's primary care provider reviewed the resident's lab work and provided feedback to the facility. -There was no documentation in Resident #64's EMR to indicate the facility followed up with the resident's primary care provider when the facility did not receive feedback from the physician regarding the resident's lab work. On 11/10/ 24 Resident #64's condition deteriorated and he was sent to the emergency room for further evaluation. C. Staff interviews Licensed practical nurse (LPN) #6 was interviewed on 1/20/25 at 1:30 p.m. LPN #6 said she was working with Resident #64 on 11/8/24. She said the resident stayed in his bed and did not go to his smoke breaks. She said he was offered fluids, but he preferred to drink only coffee. She said she contacted his physician who ordered lab work on 11/8/24. She said when lab work was completed by the lab, the lab automatically populated residents' EMRs for providers and for nurses in the facility. She said nurses acknowledged receipt of lab work by writing a progress note when it was received and what the response from the physician was. The DON was interviewed on 1/20/25 at 3:40 p.m. The DON said any changes in a resident's condition should be documented in a change of condition form. She said when lab work results were received, nursing staff should write a progress note and indicate the response from the provider. She said there was not a nursing note for Resident #64's lab work that was completed on 11/8/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065166	A. Building B. Wing	01/22/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA was interviewed on 1/20/25 at 3:40 p.m. The NHA said she contacted Resident #64's physician's office (during the survey) and the physician's office confirmed that they received a call from nursing staff on 11/9/24 asking for feedback on the resident's 11/8/24 lab work. The NHA said the physician's office was not able to comment if any feedback was provided to the nursing staff on 11/9/24. She said the nursing staff should have contacted the physician's office again to request feedback when they did not hear back from the physician.

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	065166	A. Building B. Wing	01/22/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163 Based on observations, record review and interviews, the facility failed to provide adequate supervision to keep residents free from accidents/hazards for two (#23 and #28) of five residents reviewed for accidents out of 38 sample residents. Resident #23, who was admitted on [DATE], required the use of a Hoyer lift (mechanical lift) and two-person staff assistance for transfers. Interviews during the survey revealed the resident had erratic body movements due to her diagnosis of anoxic brain damage (a condition caused by the brain being deprived of oxygen and leading to brain cell death). On 1/12/25, Resident #23 was being transferred by two staff members and hit her head on the bar of the Hoyer lift. The resident sustained a laceration to her head. Due to the facility's failures to ensure staff closely monitored the resident for erratic movements during Hoyer lift transfers, Resident #23 sustained a laceration to her head which required a transfer to the emergency department (ED) for seven sutures. Additionally, the facility failed to implement timely safety interventions for Resident #28 after the resident left the facility unsupervised on two separate occasions. Findings include: I. Failed to prevent an injury to Resident #23 during a Hoyer lift transfer A. Facility policy and procedure The Safety Precautions, Lifting policy, revised December 2009, was received from the regional director of quality and compliance (RDQC) on 1/22/25 at 4:55 p.m. It read in pertinent part, Hoyer lifts shall be operated with the use of at least two employees. Tell the resident what you are doing. Make sure you have room to move freely. Do not hurry the procedure. Before lifting or moving residents, make sure that equipment is secure (wheelchair, beds, stretchers). Report any defective equipment to your supervisor as soon as practical. B. Resident #23 1. Resident status (continued on next page)

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	065166	A. Building B. Wing	01/22/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #23, age less than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included, anoxic brain damage , muscle weakness, cognitive communication deficit and intracranial abscess and granuloma (collections of pus or inflammatory tissue in the brain). The 10/21/24 minimum data set (MDS) assessment revealed the resident was rarely or never understood through staff assessment. The resident had short-term and long-term memory deficits and was severely impaired in daily decision-making through staff assessment. The resident was dependent on staff for all activities of daily living (ADL) and mobility. 2. Resident representative interview Resident #23's representative was interviewed on 1/15/25 at 9:29 a.m. The representative said Resident #23 had only been in the facility since October 2024 so the resident was still getting acclimated to the care that was provided. The representative said she was not happy to hear that Resident #23 had to have seven stitches due to hitting her head on the Hoyer lift. 3. Observation On 1/14/25 at 3:37 p.m. certified nurse aide (CNA) #5, CNA #7 and CNA #12 were conducting a Hoyer lift transfer with Resident #23. The three CNAs told Resident #23 they were going to lay her down. Resident #23 began to become very vocal. The CNAs told her they understood that she did not like using the Hoyer lift for transfers and they would make it as quick as possible for her. The sling was left underneath the resident and was made of mesh with a hole for the resident's bottom. One CNA positioned and maneuvered the Hoyer lift while the other two connected the straps to the lift and watched the resident while the lift was being moved. They used the purple colored loops on all four straps to lift the resident. Resident #23 became more vocal and louder while she was being lifted and moved from her wheelchair to the bed. During this time she did not move erratically or move her head forward and back or from side to side. She was in more of a lying position rather than a sitting position during the transfer. 4. Record review The 1/12/25 nurse's note, entered at 7:30 p.m., documented that a CNA came out of Resident #23's room at shift change and reported that during the Hoyer lift transfer, Resident #23 was moving erratically and hit her head on the lift and was bleeding from her head. The nurse documented that the staff put pressure on the wound until the paramedics came to transfer the resident to the ED. The 1/12/25 ED after visit summary documented that Resident #23's diagnosis was a minor head injury with facial laceration. The ED did a computed tomography (CT) scan and the results were normal. The resident had seven sutures applied to her forehead above her right eye and sustained bruising to her right eye. The 1/14/25 interdisciplinary team (IDT) note documented the facility would evaluate the strap placement on the sling to prevent Resident #23's close proximity to the Hoyer lift grab bar during transfers. It further documented that during Resident #23's Hoyer lift transfers, there would be a third staff member present to evaluate the effectiveness of the interventions for 72 hours. (continued on next page)

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	065166	A. Building B. Wing	01/22/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #23's ADL care plan, updated 1/14/25, revealed that during the residents Hoyer lift transfers the sling must be on the last loop to increase the room if she started moving during the transfer. 5. Staff interviews CNA #13 was interviewed on 1/15/25 at 10:20 a.m. CNA #13 said there was always supposed to be two people present for Hoyer lift transfers, however, she said for Resident #23 currently, there were supposed to be three people because of the incident that happened with her hitting her head on the Hoyer lift. She said the third person was there to make sure that the transfer happened safely. CNA #13 said during Hoyer lift transfers, one staff member was in charge of the lift and the other staff member was there to watch the resident, to make sure that their legs did not hit the lift and to move the resident into position. She said the staff had started to watch Resident #23's head position now that the incident happened. She said Resident #23 would move erratically every once in a while but she had never seen the resident thrashing her head around. She said Resident #23 had only wiggled her body when she was transferring her. She said before the incident on 1/12/25, the staff was using the closet loop on the lift sling so that they could position resident in more of a sitting position, but she said now the staff was using the last loop on the transfer sling which positioned the resident in more of a laying position so she was less likely to hit her head. Licensed practical nurse (LPN) #4 was interviewed on 1/15/25 at 10:39 a.m. LPN #4 said Resident #23 was a Hoyer lift transfer, which normally was a two-person transfer, but she said for the next 72 hours, Resident #23 would be a three-person transfer to ensure the resident's safety. LPN #4 said the three-person transfer was the only intervention that she had heard of. CNA #9 was interviewed on 1/15/25 at 11:09 a.m. CNA #9 said Resident #23 was normally a two-person Hoyer lift transfer, but she said for the next 72 hours, she was to be a three-person Hoyer lift transfer. She said it was because of the incident that had happened on 1/12/25 when the resident hit her head on the Hoyer lift. CNA #9 said the staff were using the purple loops on her sling to position the resident in a better position to keep her head safe. III. Failed to implement timely safety interventions for Resident #28 who left the facility unsupervised on two separate occasions A. Facility policy and procedure The Elopements and Wandering policy, revised December 2007, was provided by the RDQC on 1/22/25 at 4:55 p.m. It read in pertinent part, It is the goal of the facility to provide a safe environment using the least restrictive measures available in caring for residents who exhibit wandering or exit-seeking behavior to prevent elopements. Wandering is defined as moving around the facility in a non-goal oriented manner without attempts to leave the premises. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Elopement is defined as leaving from a supervised area to an unsupervised area without staff knowledge or the appropriate level of staff supervision. The wander/elopement risk evaluation shall be completed for all residents upon admission to the facility and then quarterly thereafter or with changes in condition. Residents who score 7 (seven) or higher on the wander/elopement risk evaluation are considered to be at high risk for wandering/elopement and should have upgraded interventions developed and implemented by the interdisciplinary team (IDT), beginning with the least restrictive interventions. The interventions shall be documented in the resident's plan of care. Elopement occurs when a resident leaves the premises or a safe area without authorization (an order for discharge or leave of absence) and/or any necessary supervision to do so. Residents identified to be at high risk for elopement shall not be permitted to be on facility grounds or non-resident areas of the facility without staff supervision. If an employee discovers that a resident is missing from the facility, he/she shall: -Determine if the resident is out on an authorized leave or pass; -If the resident was not authorized to leave, initiate a search of the building(s) and then the premises if resident is not located within the building; -If the resident is not located on the premises, notify the administrator and the director of nursing services, the resident's legal representative (sponsor) if not self-responsible, the attending physician, law enforcement officials, and (as necessary) volunteer agencies (emergency management and rescue squads); -Provide search teams with resident identification information; and, -Initiate an extensive search of the surrounding area. When the resident returns to the facility, the director of nursing services or charge nurse shall: -Examine the resident for injuries; -Contact the attending physician and report findings and conditions of the resident; -Notify the resident's legal representative (sponsor) if not self-responsible; -Notify search teams that the resident has been located (if applicable); -Complete and file an incident report with all appropriate agencies; and, -Document relevant information in the resident's medical record. B. Resident # 28 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065166	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Poudre Canyon Rehabilitation and Nursing, LLC	1000 S Lemay Ave Fort Collins, CO 80524

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	1. Resident status Resident #28, age 83, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included senile degeneration of the brain (decline in cognitive function), polyneuropathy and dementia. The 11/12/24 MDS assessment revealed that Resident #28 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. The resident was independent with her walker and the majority of her ADLs. The assessment indicated that wandering was not exhibited. 2. Resident representative interview Resident #28's representative was interviewed on 1/21/25 at 4:26 p.m. The representative said that Resident #28 had left the faciity on ce to go to the gas station for candy. She said the facility called her the day that it happened (9/22/24). She said she was surprised that Resident #28 had the cognitive ability to cross the busy street in front of the facility, pay for her candy and then cross the busy street again. She said that the facility's plan was to put a wander guard on the resident on 9/22/24, but the facility did not have any wander guards because they were on back order. The representative said Resident #28 had only left the building one time. -However, Resident #28 had left the facility unsupervised on 7/20/24, prior to the 9/22/24 incident (see record review below). 3. Record review Review of Resident #28's wander risk care plan, initiated 11/27/24, revealed the resident was at risk for wandering/elopement. Interventions included assessing the resident for emotional psychological distress, assessing the resident for physical distress, encouraging the resident to stay in common areas of the building, and placing a wander guard on the resident (placed on 11/27/24). The 5/20/24 Wander/Elopement Risk evaluation documented that Resident #28 was not an elopement or wander risk. The 7/20/24 nurse note, written at 8:13 p.m., documented that Resident #28 was found outside of the building. An unknown staff member had heard the comments of her being outside and was able to bring her back into the building. The 7/20/24 nurse note, written at 8:25 p.m., documented that Resident #28 wanted to go to the store to buy candy bars. Review of Resident #28's electronic medical record (EMR) revealed there were no interventions put into place after Resident #28 left the building on 7/20/24. The 8/20/24 Wander/Elopement Risk evaluation documented that Resident #28 did not have a history of wandering or elopement and was not at risk for wandering or elopement. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a 9/22/24 facility investigation revealed that Resident #28 was seen by staff returning to the facility on [DATE], after being off facility grounds for an unknown amount of time and without staff knowledge. The investigation documented that Resident #28 reported going to the gas station for a snack. The investigation documented that she was last seen at 1:00 p.m and did not acquire any injuries. The investigation further revealed that Resident #28 had a lack of insight to her own limitations and was forgetful and was at risk of being unable to return to the facility. The investigation revealed that Resident #28 was placed on frequent checks, her care plan was updated, she was assessed for a wander guard and a wander guard was placed. -However, the care plan was not initiated until 11/27/24, four months after the resident first left the facility unsupervised on 7/20/24 and two months after the resident's second incident of leaving the facility unsupervised on 9/22/24 (see care plan above). -Additionally, a wander guard was not placed on Resident #28 until 11/27/24, despite the facility documenting a wander guard was placed on the resident following the 9/22/24 incident (see facility investigation above). -Review of Resident #28's EMR revealed the facility failed to conduct a Wander/Elopement Risk evaluation following the resident's second incident of leaving the facility unsupervised on 9/22/24. The 1/20/25 Wander/Elopement Risk evaluation (completed during the survey) documented that the resident was a high risk for elopement. 4. Staff interviews LPN #4 was interviewed on 1/15/25 at 3:45 p.m. LPN #4 said she knew that Resident #28 had a wander guard on because she had left the building before. She said she had only heard of the resident leaving the building once before and she was unaware if the resident had left the facility unsupervised more than once. CNA #8 was interviewed on 1/16/25 at 12:02 p.m. CNA #8 said Resident #28 did not wander but he said he had seen her come out of her room to get something to drink. He said he had not seen Resident #28 outside of the building before. CNA #10 was interviewed on 1/16/25 at 12:38 p.m. CNA #10 said she had never seen Resident #28's wander guard and she had never heard of the resident leaving the building. CNA #10 said all the doors to the outside of the facility had a wander guard alarm system on them. LPN #4 was interviewed again on 1/16/25 at 12:45 p.m. LPN #4 said she had never seen Resident #28 try to exit the building. She said the resident did wander but she did not exit-seek. CNA #11 was interviewed on 1/21/25 at 12:45 p.m. CNA #11 said Resident #28 wandered to the front sitting area but she had never seen her outside by herself. She said she did not think that the resident had ever been allowed outside by herself. CNA #11 said the facility had a binder with a list of residents who were on elopement and wander precautions. (continued on next page)

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	065166	A. Building B. Wing	01/22/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	LPN #5 was interviewed on 1/21/25 at 1:00 p.m. LPN #5 said Resident #28 was only allowed to go outside with either family or staff members. She said she was unaware of the resident ever being outside by herself. The director of nursing (DON) and the nursing home administrator (NHA) were interviewed together on 1/21/25 at 2:00 p.m. The DON said Resident #28 had a history of wandering and exit seeking and she needed redirection and reorientation to where she was. The NHA said Resident #28 left the building on 9/22/24 and the interventions that were placed after the incident were frequent checks. She said no other interventions were placed. She said Resident #28 was never independent to be outside by herself. She said Resident #28 reported to her that she went to the gas station and came back. She said the facility had a care conference with her daughter on 9/24/24 and had a discussion about the wander guard and decided that frequent checks were appropriate at that time. The NHA said Resident #28 had not had any incidents of leaving the building since September 2024. However, she said in November 2024 the IDT decided to place a wander guard on the resident for extra precautions. The NHA said Resident #28 was reassessed for the wander guard based on her history of leaving the building and the incident in September 2024. She said new interventions added in November 2024 included behavior monitoring, care plan updates, a wander guard assessment and placing a wander guard. She said the current management, including herself, was not aware Resident #28 had left the building in July 2024, as they had not worked in the building at that time.The NHA said there was no investigation of the 7/20/24 elopement incident for Resident #28. The NHA said the facility would re-educate the staff on how to properly complete a Wander/Elopement Risk assessment, because when the facility reassessed the resident, they realized that the wander assessments were not done correctly.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51915 Based on observation, record review, and interviews, the facility failed to use a person-centered approach when determining the use of bed rails for one resident (#1) out of 38 sample residents. Specifically, for Resident #1, the facility failed to: -Assess the resident for the safe use of bed rails, including assessment for risk of entrapment prior to installing the bed rails; -Create and document a personal care plan for the safe use of bed rails; -Obtain consent from the resident and/or the resident's representative before bed rails installation, including informing them of the risks versus benefits of bed rails; -Obtain a physician's order for the bed rails; and, -Conduct quarterly assessments of the bed rails to evaluate their continued need and safety. Findings include: I. Facility policy and procedure The Side Rail policy, revised on 12/19/16 was received from the nursing home administrator (NHA) on 1/22/25 at 4:15 p.m. It read in pertinent part, An assessment of the resident will be made to include a review of the following: device to be used; indication for use; cognitive status; physical status; pertinent history, as applicable; anticipated benefits; a review of how the device impacts the resident's freedom of movement; a review of whether the resident has the potential to become entrapped or harmed; and, risk factors associated with use of the device. The use of side rails as an assistive device will be addressed in the resident care plan. Consent for side rail use will be obtained from the resident or legal representative, after presenting potential benefits and risks and documented within the assessment. If side rail usage is appropriate, the facility will obtain an order for use from the attending physician. When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk of entrapment. II. Resident #1 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065166	A. Building B. Wing	01/22/2025

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Resident status Resident #1, age 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included generalized idiopathic epilepsy and epileptic syndromes (seizure disorders), cognitive communication deficit, history of traumatic brain injury, sleep apnea, depression and gastro-esophageal reflux disease without esophagitis (GERD). The 12/10/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. She required assistance from one person with activities of daily living (ADLs). The assessment documented Resident #1 did not use bed rails. -However, observations revealed the resident had bed rails in place (see below). B. Resident interview and observations Resident #1 was interviewed on 1/13/25 at 9:30 a.m. Resident #1 said she had temporarily moved to a different bedroom because of an issue with the heater. She said she needed bed rails on the bed to help her get up and move around. Resident #1 was lying in her bed and there were no bed rails attached to the bed. Resident #1 was interviewed again on 1/21/25 at 5:30 p.m. The resident was observed in her room in bed. The side rails were present on her bed. She said they were installed last week. C. Record review Review of Resident #1's comprehensive care plan did not reveal documentation regarding the use of a bed rail. Review of Resident #1's electronic medical record (EMR) did not reveal an assessment for the safe use of side rails, a physician's order for the use of the bed rails or a consent for the use of the bed rails. III. Staff interviews The director of nursing (DON) and the NHA were interviewed together on 1/13/25 at 3:00 p.m. They said the resident was moved to a different room while the facility was working on repairing the heater. The NHA was interviewed again on 1/22/25 at 4:45 p.m. The NHA said Resident #1 had been utilizing bedrails She admitted the bedrail assessment should have been completed prior to installing the bed rails.

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	065166	A. Building B. Wing	01/22/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50315 Based on observations, record review and interviews, the facility failed to ensure the medication administration error was not greater than five percent. Specifically, the facility's medication administration error rate was 8% (percent), or two errors out of 25 opportunities for error. Findings include: I. Manufacturer's recommendations The Novolog medication package insert (February 2023) was retrieved on 2/3/25 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.novo-pi.com/novolog.pdf. It revealed in pertinent part, Giving an air shot before injection (after needle application): before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: turn the dose selector to two units, hold your Novolog flex pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in. the dose selector should return to zero. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times. The Humalog medication package insert (July 2023) was retrieved on 2/3/25 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/020563Orig1s202,205747Orig1s028Lbl.pdf. It revealed in pertinent part, Priming your insulin pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. II. Observations of medication administration for Resident #18 On 1/14/25 at 10:59 a.m., licensed practical nurse (LPN) #1 was observed during medication administration. She checked Resident #18's blood sugar which was 352 milligrams (mg)/deciliter (dl). She took the Novolog pen out of the medication cart and pulled off the cap, wiped the stopper with an alcohol pad and attached the needle. She prepared 22 units of the Novolog solution for Resident #18. She said eight units were for her scheduled insulin and 14 units were the sliding scale order, which was verified correct per the physician's order. She turned the dose to 22 units and went into the resident's room. She did not prime the insulin pen. She wiped Resident #18's lower abdomen with an alcohol wipe and injected the medication into her abdomen. -LPN #1 failed to prime the Novolog insulin pen prior to drawing up the 22 units of insulin. III. Observations of medication administration for Resident #46 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065166	A. Building B. Wing	01/22/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/25 at 11:12 a.m., LPN #1 was observed during medication administration. She checked Resident #46's blood sugar which was 227 mg/dl. She took the Humalog pen out of the medication cart, pulled off the cap, wiped the stopper with an alcohol pad and attached the needle. She prepared eight units of Humalog solution for Resident #46. She said four units were for her scheduled insulin and 4 units were the sliding scale order, which was verified as correct per the physician's order. She turned the dose to eight units and went into the resident's room. She did not prime the insulin pen. She wiped Resident #46's right upper arm with an alcohol wipe and injected the medication into her arm. -LPN #1 failed to prime the Humalog insulin pen prior to drawing up the eight units of insulin. IV. Staff interviews Nurse practitioner (NP) #1 was interviewed on 1/16/25 at 2:33 p.m. NP #1 said it was best practice to prime an insulin pen prior to administration so the resident got the full dose of insulin. The director of nursing (DON) and the regional director of quality and compliance (RDQC) were interviewed on 1/16/25 at 2:35 p.m. The DON said insulin pens should be primed with two units of insulin or whatever the specific manufacturer's recommendation was. Cross reference F760: failure to be free from significant medication errors.

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	065166	A. Building B. Wing	01/22/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 50315 Based on observations, record review and interviews, the facility failed to ensure that residents were free from significant medication errors for two (#18 and #46) of two residents reviewed for medications errors out of 38 sample residents. Specifically, the facility failed to ensure that Resident #18 and Resident #46 were administered the correct dose of insulin by properly priming the insulin pen before insulin administration. Findings include: I. Manufacturer recommendations The Novolog medication package insert (February 2023) was retrieved on 2/3/25 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.novo-pi.com/novolog.pdf. It revealed in pertinent part, Giving an air shot before injection (after needle application): before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: turn the dose selector to two units, hold your Novolog flex pen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in. The dose selector should return to zero. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times. The Humalog medication package insert (July 2023) was retrieved on 2/3/25 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/020563Orig1s202,205747Orig1s028Lbl.pdf. It revealed in pertinent part, Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. II. Observations On 1/14/25 at 10:59 a.m., licensed practical nurse (LPN) #1 was observed during medication administration. She checked Resident #18's blood sugar which was 352 milligrams (mg)/deciliter (dl). She took the Novolog pen out of the medication cart and pulled off the cap, wiped the stopper with an alcohol pad and attached the needle. She prepared 22 units of the Novolog solution for Resident #18. She said eight units were for her scheduled insulin and 14 units were the sliding scale order, which was verified correct per the physician's order. She turned the dose to 22 units and went into the resident's room. She did not prime the insulin pen. She wiped Resident #18's lower abdomen with an alcohol wipe and injected the medication into her abdomen. -LPN #1 failed to prime the Novolog insulin pen prior to drawing up the 22 units of insulin. (continued on next page)

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	065166	A. Building B. Wing	01/22/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/25 at 11:12 a.m., LPN #1 was observed during medication administration. She checked Resident #46's blood sugar which was 227 mg/dl. She took the Humalog pen out of the medication cart, pulled off the cap, wiped the stopper with an alcohol pad and attached the needle. She prepared eight units of Humalog solution for Resident #46. She said four units were for her scheduled insulin and 4 units were the sliding scale order, which was verified as correct per the physician's order. She turned the dose to eight units and went into the resident's room. She did not prime the insulin pen. She wiped Resident #46's right upper arm with an alcohol wipe and injected the medication into her arm. -LPN #1 failed to prime the Humalog insulin pen prior to drawing up the eight units of insulin. Cross reference F759: failure to ensure the medication rate was under 5%. III. Staff interviews Nurse practitioner (NP) #1 was interviewed on 1/16/25 at 2:33 p.m. NP #1 said it was best practice to prime an insulin pen prior to administration so the resident got the full dose of insulin. The director of nursing (DON) and the regional director of quality and compliance (RDQC) were interviewed on 1/16/25 at 2:35 p.m. The DON said insulin pens should be primed with two units of insulin or whatever the specific manufacturer's recommendation was.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50315 Based on observations and interviews, the facility failed to ensure medications and biologicals were properly stored and labeled in accordance with professional standards in one of two medication carts and one of two medication storage rooms. Specifically, the facility failed to: -Ensure expired medications were removed from the medication cart; and, -Ensure all medications were labeled with resident information. Findings include: A. Professional references The United States Food and Drug Administration (USFDA) (10/31/24) Don't Be Tempted to Use Expired Medicines, was retrieved on 1/23/25 from https://www.fda.gov/drugs/special-features/dont-be-tempted-use-expired-medicines. It documented in pertinent part, Expired medical products can be less effective or risky due to a change in chemical composition or a decrease in strength. Certain expired medications are at risk of bacterial growth and sub-potent antibiotics can fail to treat infections, leading to more serious illnesses and antibiotic resistance. Once the expiration date has passed there is no guarantee that the medicine will be safe and effective. If your medicine has expired, do not use it. The National Institutes of Health (NIH) (July 2017) Strengthen Your Resolve: No Unlabeled Containers Anywhere, Ever, was retrieved on 1/23/25 from https://pmc.ncbi.nlm.nih.gov/articles/PMC5481289/#:~:text=Discard%20unlabeled%20medications,event%20as%20a%20hazardous%20condition. It documented in pertinent part, Discard unlabeled medications. Don' t assume that you know what is contained in an unlabeled syringe, cup or basin. Discard any unlabeled solution or medication found in the perioperative area or procedural areas and report the event as a hazardous condition. B. Facility policy and procedure The Medication Labeling and Storage policy, revised 2001, was provided by the regional director of quality and compliance (RDQC) on 1/22/25 at 4:55 p.m. It documented in pertinent part, If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. The medication label includes at minimum: medication name, prescribed dose, strength, expiration date, resident's name, route of administration and appropriate instructions and precautions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065166	A. Building B. Wing	01/22/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Observations On 1/15/25 at 5:30 p.m. the medication cart and treatment cart on the secure unit were observed with licensed practical nurse (LPN) #3. The following items were found: -One bottle of nitroglycerin lingual spray with an expiration date of June 2023; and, -One container of nitroglycerin sublingual tablets with no label indicated which resident it belonged to. IV. Staff interviews LPN #3 was interviewed on 1/15/25 at 5:30 p.m. LPN #3 said usually the night shift nurse would audit the medication carts for expired medications. She said she was going to let the director of nursing (DON) know about the expired medication and the unlabeled medication. She said she would dispose of the medications properly. The DON and the RDQC were interviewed together on 1/16/25 at 2:35 p.m. The DON said the medications carts and storage rooms were reviewed weekly. She said this was done by herself or a unit manager. She said if a nurse found an expired medication, the nurse should have removed the medication and destroyed it. She said medications that come from the pharmacy come with resident labels.

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	065166	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Poudre Canyon Rehabilitation and Nursing, LLC	1000 S Lemay Ave Fort Collins, CO 80524

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 51163 Based on observation, record review and interviews, the facility failed to serve food that was palatable and attractive. Specifically, the facility failed to ensure that the resident's food was palatable in taste, texture and appearance. Findings include: I. Resident interviews Resident #39 was interviewed on 1/13/25 at 11:49 a.m. He said that the food did not taste good and was not presentable. Resident #59 was interviewed on 1/13/25 at 2:10 p.m. He said that the food was not good. He said the taste of the food depended on who was cooking and what staff was working. Resident #44 was interviewed on 1/13/25 at 3:23 p.m. She said that the food tasted horrible and that the food does not look presentable. Resident #217 was interviewed on 1/13/25 at 3:37 p.m. She said the facility did not have an alternate menu. She said the kitchen would often close by the time she got her meal, so if she did not like what was served she could not get something else. Resident #50 was interviewed on 1/14/25 at 9:43 a.m. He said the food was not good. He said the food did not taste good. He said the facility did not have an alternative menu., Resident #46 was interviewed on 1/14/25 at 10:21 a.m. He said the meat and vegetables were served over cooked. He said the canned fruit tasted like the can. He said he would like some fresh fruit. II. Resident group interview The resident group interview was conducted on 1/15/25 at 1:04 p.m. The group consisted of five residents (#2, #37, #51, #39 and #58) who were interviewable based on assessment by the facility. All of the residents in the group interview said the food was not palatable. Some of the comments were as follows: -The food was questionable at best; -The food did not look good; -Some of the food was too spicy; and, -The dietary manager (DM) did not listen to the residents or fix the issues. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Record review The food committee meetings from October 2024 through January 2025 were reviewed. The 10/7/24 food committee minutes documented that the residents wanted more fruit added to the menu and that some of the food was too salty. The 12/2/24 food committee minutes documented that they would like brussel sprouts and some other vegetables off the menu. -The minutes did not mention what actions were taken regarding expressed concerns and if residents were satisfied with resolution. IV. Observations On 1/15/25 at approximately 12:30 p.m. a test tray of a regular diet was immediately evaluated by four surveyors after the last resident was served their room tray for lunch. The test tray was not served palatable and consisted of white rice pilaf, white gravy, four meatballs, steamed brussel sprouts, white bread roll and a slice of angel food cake with canned peaches over the top. The rice pilaf was crunchy and under cooked. The gravy was salty. -The outside of the meatballs were crunchy and hard to bite through. The brussel sprouts were slightly yellow and greyish in color, the consistency was mushy and were overcooked. The angel food cake and the peaches that were on tope were sweet. V. Staff interview The DM was interviewed on 1/22/25 at 4:30 p.m. He said he met with residents every month to discuss food feedback and choices. He said to his knowledge residents were satisfied with food choices they had. The DM said he did taste the rice pilaf on 1/15/25 lunch time and he did not think it was undercooked. 37166

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 37166 Based on record review and interviews, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented in order to facilitate improvement in the lives of nursing home residents through continuous attention to quality of care, quality of life and resident safety. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to freedom from abuse that rose to the level of immediate jeopardy. Findings include: I. Review of the facility's regulatory record revealed it failed to operate a QAPI program in a manner to prevent repeat deficiencies. F600 Abuse prevention During a recertification survey on 7/13/23, F600 was cited at a G level scope and severity, isolated, actual harm. The facility had identified and corrected the deficient practice prior to the survey and therefore F600 was cited at past non-compliance. -However, the facility failed to maintain compliance. During a recertification survey on 1/15/25, F600 was cited at K level scope and severity, pattern, immediate jeopardy to residents health and safety. Failure to monitor sexually inappropriate behavior for the resident with a history of such behaviors. F759 Medication administration error rate above five (%) percent During a recertification survey on 7/13/23, F759 was cited at a D level scope and severity, isolated, no actual harm with potential for more than minimal harm. During a recertification survey on 1/15/25, F759 was cited at a D level scope and severity, isolated, no actual harm with potential for more than minimal harm. II. Staff interviews The nursing home administrator (NHA) was interviewed on 1/15/25 at 5:30 p.m. The NHA said Resident #50 was admitted to the facility prior to change of ownership. She said the resident's history of sexually inappropriate behavior was mentioned in his medical records, however he did not display any inappropriate behaviors until the incident on 1/1/25. She said the facility reviewed all of the residents who might have had a history of sexually inappropriate behaviors to ensure proper interventions were put in place. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The medical director (MD) was interviewed on 1/16/25 at 9:50 a.m. The MD said he was not aware that Resident #50 had a history of sexually inappropriate behaviors. He said it was brought to his attention this week. He said primary care and mental health providers were involved in identifying the best course of treatment for this resident. The NHA was interviewed a second time on 1/22/25 at 5:30 p.m. The NHA said QAPI meetings were conducted monthly. She said sexually inappropriate behaviors and Resident #50 were not brought up in the meetings and have not been identified as a problem.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50315 Based on observation, record review and interviews, the facility failed to establish an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and healthcare associated infections. Specifically, the facility failed to: -Ensure staff donned (put on) appropriate personal protective equipment (PPE) when providing care to a resident on enhanced barrier precautions (EBP); and, -Ensure sanitary conditions related to the ice box Findings include: I. Failure to ensure staff followed EBP when providing care to a resident with a wound A. Professional reference According to the Centers for Disease Control and Prevention (CDC) Frequently Asked Questions (FAQs) About Enhanced Barrier Precautions (EBP) In Nursing Homes (6/28/24) retrieved on 1/27/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html, EBP are an infection control strategy that involves wearing gowns and gloves during high-contact resident care activities. Enhanced Barrier Precautions are recommended for residents with any of the following: infection or colonization, or a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a multi drug resistant organism (MDRO). B. Facility policy and procedure The Infection Prevention and Control Program policy and procedure, revised 12/19/16, was received from the regional director of quality and compliance (RDQC) on 1/22/25 at 4:55 p.m. It documented in pertinent part, The infection prevention and control program bases standards of practice and protocols on recommendations from appropriate government agencies such as the center for disease control (CDC) and the occupational safety and health administration (OSHA). The facility will utilize practices with employees to reduce the risk that employees will expose residents to infection including taking precautions to reduce the risk for spread of infection from employees to residents by utilizing standard precautions. C. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #1 was observed on 1/15/25 at 12:30 p.m. while completing wound care for Resident #10. She gathered the supplies and walked into the resident's room. There was a sign on the door that indicated the resident was on EBP. There was a caddy hanging on the inside of the door with gowns, masks and gloves. RN #1 was wearing a mask prior to entering the resident's room. She applied clean gloves. She did not put a gown on. She cleaned the wound and applied medicated ointment to the wound. She removed a stat lock (device to hold catheter in place) because she said it was not in the correct location. She removed the gloves and washed her hands. She said Resident #10 was on EBP due to his foley catheter. She said she should have put on a gown and did not think about it when entering the room to complete wound care. D. Staff interviews The infection preventionist (IP), the RDQC, the director of nursing (DON) and the assistant director of nursing (ADON) were interviewed together on 1/22/25 at 3:00 p.m. The IP said Resident #10 was on EBP for his foley catheter. She said any resident that had chronic wounds, a foley catheter, history of (MRSA), ostomies and nasogastric tubes qualified a resident to be on EBP. She said the nurse providing wound care to Resident #10 should have put on a gown while providing care to the resident. II. Failure to ensure sanitary conditions related to the ice box A. Professional reference According to the Centers for Disease Control and Prevention (CDC) Guidelines for Environmental Infection Control in Health-Care Facilities (July 2019) retrieved on 1/27/25 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.cdc.gov/infection-control/media/pdfs/Guideline-Environmental-H.pdf, Ice and ice-making machines also may be contaminated via improper storage or handling of ice by patients and/or staff. Suggested steps to avoid this means of contamination include: minimizing or avoiding direct hand contact with ice intended for consumption, using a hard-surface scoop to dispense ice and installing machines that dispense ice directly into portable containers at the touch of a control. B. Observations On 1/15/25 at 12:15 an unidentified resident She opened the white and blue ice box that was in the dining room and used her personal cup to scoop the ice directly from the ice box. The resident did not use an ice scoop. An unidentified certified nursing assistant (CNA) was present in the dining room. C. Staff interviews The IP, the RDQC, the DON and the ADON were interviewed together on 1/22/25 at 3:00 p.m. The IP said the residents were not allowed to scoop their own ice from the ice boxes. She said the staff were supposed to help them use a designated scoop to get them ice. She said the staff and the residents should not use their personal cups to scoop ice directly from the ice box.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37166 Based on observations and interviews, the facility failed to provide a safe, functional and comfortable environment on two of five units. Specifically, the facility failed to: -Ensure the utility door room near the dining room, between the 300 and 400 units, was closed and not accessible to residents; and, -Ensure room [ROOM NUMBER] on the 500 unit, which was under construction, was not accessible to residents. Findings include: A. Observations On 1/13/25 at 11:35 a.m. the door to the utility room near the dining room between the 300 and 400 units was slightly open. Multiple computer servers and cables were visible in the room. On 1/14/25 at 10:30 a.m. the door to the utility room near the dining room between the 300 and 400 units was open again and had a medication cart next to the room. -The door to the room had not been closed by staff when the medication cart had been placed next to the doorway. On 1/15/25 at 3:40 p.m. the door to the utility room near the dining room between the 300 and 400 units was slightly open again and there was a two-wheel walker folded up and leaning against the wall outside the open door. -The door to the room had not been closed by staff when the walker had been placed next to the doorway. On 1/22/25 at 1:50 p.m. the door to room [ROOM NUMBER] was unlocked. Upon opening of the door, the room revealed there were mechanical tools in the room, such as a drill, nails and screws. The dry wall panel was removed from one of the walls and revealed exposed plumbing. The door to the room was not locked and the unsafe contents in the room were accessible to residents on the 500 unit. B. Staff interviews The maintenance director (MTD) was interviewed on 1/16/25 at 3:54 p.m. The MTD said the utility room with the computer equipment had always had the door open since he had worked at the facility. He said he was told it was because the room got too hot and so it needed ventilation. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing home administrator (NHA) was interviewed on 1/22/25 at 5:20 p.m. The NHA said all utility room doors should be closed and should not be accessible to residents for safety reasons. She said she was not aware that room [ROOM NUMBER] had tools in it and was still accessible to residents. She said she would contact the MTD to ensure the tools were not accessible to residents.